WORKFORCE SERVICES REHABILITATION

Utah State Office of Rehabilitation
Pre-Employment Transition Services
Community Partner Referral Form-77

Student Name:_____DOB:_____SSN (if Available):_____

Race (Check all that apply):

American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ White

Ethnicity (Check one): ☐ Individual is HIspanic or Latino ☐ Individual is not Hispanic or Latino

School Attending:_____

Individual is a student with a disability and has a section 504 plan
Individual is a student with a disability and has an IEP
Individual is a student with a disability who does not have a section 504 accommodation and is not receiving services on an IEP

Teacher name/current Grade: _____

VR Client (if known)?_____If yes, counselor Name/office:_____

Name of Pre-Ets Services Service(s) (if known):_____

Estimated Date of Service(s):_____

Notes:

Completed by (school personnel) :_____Title: _____

Agency/
LEA:_____Date:_____

Student Signature:_____Parent/Guardian Signature:_____

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Release of Information Exchange

The purpose of this exchange of information is to facilitate vocational rehabilitation pre-employment transition services. Care will be taken by all agencies involved to release only that information which is required for effective and efficient implementation of services. Confidential information to be included in this interagency information exchange agreement may include: Educational, psychological, medical, social, and vocational information relevant to your needs to participate in services. This release will not be used for detailed medical or psychological information.

Agencies Share Access to Confidential Information

Utah State Office of Rehabilitation
Division of Rehabilitation Services:

Address:_____

Contact Person:_____

Phone:_____

Agency Name:_____

Address:_____

Contact Person:_____

Phone:_____

Utah State Board of Education School District:

Address:_____

Contact Person:_____

Phone:_____

Agency Name:_____

Address:_____

Contact Person:_____

Phone:_____

I understand that my records are protected under the State and Federal regulations as well as professional codes of ethics governing confidentiality and cannot be released or disclosed without my written consent, unless otherwise provided for in the State and Federal regulations. I authorize the release and/or disclosure of information between the agencies listed above with the restriction that the information cannot be passed on to any other person or entity/agency. I understand that this consent is effective from the date below until the final day of the month following the termination of my currently open vocational rehabilitation program(s). I understand I may revoke this consent at any time by sending written notification to the above listed agencies.

_____ _____

Student Signature Parent/Guardian Signature

_____ _____

Witness Date